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Topical Review:

Building competency:

Professional skills for pediatric psychologists in integrated primary care settings¹

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ABSTRACT

Objectives: In the midst of large-scale changes across our nation's healthcare system, including the Affordable Care Act (ACA) and Patient-Centered Medical Home (PCMH) initiatives, integrated primary care models afford important opportunities for those in the field of pediatric psychology. Despite the extensive and growing attention this subspecialty has received in recent years, a comprehensive set of core professional competencies has not been established.

Methods: A subset of an Integrated Primary Care Special Interest Group used two well-established sets of core competencies in integrated primary care and pediatric psychology as a basis to develop a set of integrated pediatric primary care-specific behavioral anchors.

Conclusions The current manuscript describes these behavioral anchors and their development in the context of professional training as well as with regard to Triple Aim goals and securing psychology's role in integrated pediatric primary care settings.

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The majority of individuals in the United States pursue and receive care for medical, behavioral, and mental health² concerns in primary care settings. Primary care is often regarded as the “de facto” behavioral health system in the United States (deGruy, 1996), with 40-70% percent of people seeking behavioral health services exclusively in primary care (HRSA, 2008; Kessler & Stafford, 2008). Pediatric psychologists working in integrated primary care (IPC) settings work closely with physicians, nurses, social workers, and allied health care professionals to promote wellness, broadly conceived. As experts in human behavior, psychologists work closely with integrated team members to identify processes that enhance healthy behaviors and lifestyles, promote treatment adherence, and reduce disease (APA, 2014). Psychologists also provide early intervention services, assessment, and treatment for behavioral, emotional, and developmental needs to promote overall health and well-being for children and families (Stancin & Perrin, 2014).

A number of advantages of IPC services have been reported, though the majority of studies to date have examined outcomes in adult populations. Benefits to providing behavioral health treatment in primary care settings compared to usual care include decreased wait times for behavioral health services (Pomerantz et al., 2008), increased treatment engagement and adherence (Pomerantz et al., 2008), improved outcomes for physical and behavioral health concerns in youth (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015) and adults (Butler, Kane et al, 2008), and increased patient satisfaction in adolescents (Asarnow, 2005) and adults (Pomerantz et al., 2008; Unützer et al., 2002). Compared to traditional behavioral health services, IPC has

² We use the term “behavioral health” throughout this manuscript to refer to developmental, behavioral and mental health conditions of pediatric patients.

been associated with improved patient engagement in treatment (Bartels et al, 2004). Further, medical providers have also been shown to prefer IPC services to other behavioral health delivery models with increased satisfaction for coordinating medical and behavioral health services, better communication, more comprehensive services, and less stigma for patients seeking services (Gallo et al., 2004; Kolko et al., 2014).

Recent changes to our nation's health care delivery system generated by the Affordable Care Act (ACA) and Patient-Centered Medical Home (PCMH) initiatives focus on the delivery of efficient, cost-effective, and quality health care services in primary care settings (Rozenky, 2014). The ACA has called for increased integration of physical and behavioral health services with increased funding for early detection and intervention for behavioral health problems, focus on high-need populations, and increased emphasis on team-based care to improve patient experience and clinical quality, and to reduce cost. These are not new initiatives, as the integration of psychology services in pediatric primary care was first described in 1967 (Smith, Rome, & Freedheim, 1967) and later expanded on by Carolyn Schroeder (Schroeder, 1979, 2004). Schroeder's early model of psychology services in pediatric primary care settings included clinical, teaching, research, community advocacy, and public health components with opportunities for "call-in" hours for parents, parenting groups, brief visits for parents to discuss individual concerns, and developmental screening (Stancin & Perrin, 2014). IPC services later expanded to include prevention programs and direct clinical care for children and families. Despite pediatric psychology's half-century of experience and the increased focus on primary care psychology in recent years, there is no generally accepted articulation of professional competencies that pediatric psychologists must have to work effectively in pediatric primary care settings. Such competencies are of particular importance if psychologists are to differentiate

their skill sets from other behavioral health providers and to present a compelling case of their “value added” to IPC settings (Stancin & Perrin, 2014).

In addition to changes referenced in the ACA and PCMH model of care, the Triple Aim is often cited as a national goal for improving health care and is particularly relevant to the primary care setting. This initiative defines success in terms of three markers: 1) improved patient experience of care, including quality and satisfaction, 2) improved population health, 3) and reduced per capita cost of health care (McDaniel & deGruy, 2014). Primary care psychologists are in a key position to align themselves with physician colleagues in delivering Triple Aim objectives as psychology services in this setting are focused on prevention, early detection, and team-based care to improve overall health (Berwick, Nolan, & Whittington, 2008). For a number of years, psychologists in primary care have been integrally involved in identifying and referring children and adolescents with developmental, behavioral, physical, or mental health concerns through screening initiatives in primary care (Earls & Hay, 2006; Foy, Kelleher, & Laraque, 2010; Gardner, Lucas, Kolko, & Campo, 2007; Jellinek, Murphy, Little, Pagano, Comer, & Kelleher, 1999; Pierce, Rozier, & Vann, 2002). While Triple Aim objectives are well-known, processes investigating outcomes for these initiatives have yet to be conducted. With knowledge in program design, implementation, and evaluation, psychologists can lead physicians and other primary care providers in investigating efforts to enable early detection of behavioral, socio-emotional, and developmental concerns, promote health and reduce disease, increase cost-effectiveness for medical and psychological services, and facilitate referrals to specialty providers.

Two recent documents (McDaniel et al., 2014; Palermo et al, 2014) provide a context for outlining competencies specific to pediatric IPC practice, but fall short of needed specificity.

The Task Force on Recommendations for Training of Pediatric Psychologists was challenged by the Society of Pediatric Psychology (SPP) to provide a comprehensive overview of key knowledge areas essential to the development of skills in pediatric psychology (Spirito et al., 2003). In response to the call from SPP to revise and update these original competencies, Palermo and colleagues (2014) provided recommendations for a broadly defined scope of pediatric psychology practice, with core competencies and behavioral anchors for psychologists and trainees at various developmental stages. These competencies were created to guide training and assessment of pediatric psychologists in diverse pediatric settings and with a broad range of activities, but with few concrete behavioral anchors specific to IPC settings. Concurrently, an American Psychological Association (APA) IPC workgroup was creating a different set of competencies for psychologists in diverse integrated primary medical care settings (McDaniel et al, 2014). Competencies were described with behavioral anchors geared largely toward general or adult patient populations with few specific pediatric descriptors.

With the recent and ongoing focus on integrating mental and physical health in pediatric primary care settings, the Board of Directors of SPP appointed an Integrated Primary Care (IPC) Task Force (Sturm & Stancin, 2013). This Task Force initially consisted of senior psychologists with experience developing integrated care programs for university and hospital-based psychology training programs. Goals of this group included creating a network of professionals to assist in refining standards for professional competency, assisting in development of training models, and encouraging evidence-based approaches to service delivery. Goals of this group were to develop a set of integrated pediatric primary care-specific behavioral anchors that are consistent with the frameworks of both the McDaniel et al. (2014) and Palermo et al (2014) competency documents.

The 2014 Palermo et al. SPP competencies provided the basic framework for the IPC Task Force document with specific competencies defined within the six clusters related to the field of pediatric psychology: science, professionalism, interpersonal, application, education, and systems (Palermo et al., 2014). In addition to the six clusters, Palermo and colleagues (2014) added a seventh cluster entitled “crosscutting knowledge in pediatric psychology.” The competencies defined in the crosscutting knowledge cluster were determined to be broad enough to the spectrum of settings in which pediatric psychologists work, including IPC, to stand alone; therefore, behavioral anchors for this cluster were not needed. The IPC Task Force sought to add behavioral anchors to the original six competencies that exemplify the unique role of pediatric psychologists in IPC settings. To stay consistent with the cluster numbering outlined by Palermo and colleagues (2014), the crosscutting knowledge cluster is labeled as number one and the six core competencies are labeled as numbers two through seven. Refer to Table 1 for a complete list of behavioral anchors for the six core competencies.

The process for creating the behavioral anchors maintained the structure and organization of six of the seven 2014 SPP competencies and 48 sub-competencies. Shortly following the development of the IPC Task Force, this group sought formal recognition as a special interest group (SIG) through SPP. The SIG quickly expanded to include professionals and trainees from across the country with a range of years and professional experience working in pediatric integrated care settings. A work group comprised of twelve members from the SPP IPC SIG was convened to suggest anchors, or specific behaviors, practices, and expectations for each competency. Group members included pediatric psychologists with particular expertise conducting research and providing clinical services in IPC settings across the country. Members were asked to reference the APA IPC task force competencies (McDaniel, 2014) when creating

potential behavioral anchors to facilitate consistency across documents with particular focus on how anchors reflect work of pediatric psychologists in IPC settings. The proposed anchors were then circulated amongst the work group who used consensus methodology to streamline and retain the most appropriate anchors. Coherence and consistency were emphasized as the edits were completed.

Consistent with the general trend in professional psychology of focusing on competency-based training and learning, the proposed behavioral anchors are meant to inform curricula at undergraduate to postgraduate training programs interested in preparing their learners to be members of IPC teams, as well as provide context for psychologists approaching IPC settings as a new area of practice. Developmentally, these anchors were created with early career psychologists and those new to IPC settings as the target audience; however, anchors could also be used to enhance interest in psychology services in integrated care settings for undergraduate and graduate students. As with many other sets of competencies and behavioral anchors, the anchors are intended to be suggestive rather than exhaustive or definitive. Although we did not change the original competencies in any way, we do want to acknowledge the evolving terminology that best reflects the collaborative nature of the work that psychologists do in the medical setting. As our fields have worked to integrate in more meaningful ways, terminology has shifted from terms like ‘multidisciplinary’ and ‘interdisciplinary’ to the newer preferred term ‘interprofessional’ (Interprofessional Education Collaborative Expert Panel, 2011). The term ‘interprofessional’ incorporates both collaborative endeavors and cross-discipline training needed to truly integrate multiple fields into one team. As such, while we did not change the use of the term ‘interdisciplinary’ throughout the competency wording in Appendix A, we chose to

use the term ‘interprofessional’ in the main body of the manuscript to fully capture the level of integration needed for a strong IPC setting as indicated by the Expert Panel.

Competency Clusters

The complete list of fifty-four competencies and behavioral anchors can be found in Table 1.

Science

The role of science is strongly rooted in the field of pediatric psychology. Our ability to produce and contribute to research is one clear way in which our field differentiates itself from other helping professions. As the medical climate shifts with legislation such as the ACA, there is mounting emphasis on accountability and outcome measurement (Miller, 2015). Increasingly, psychologists are being asked to demonstrate effectiveness of their work, not only to secure their roles on medical teams, but also to justify payment by insurance companies who are increasingly requiring measurable effectiveness of psychological treatment. As such, the role of science in the field of psychology is more pertinent than ever.

Within the science cluster, pediatric IPC psychologists can be particularly valuable by designing, executing, and disseminating research with outcomes relevant to the setting. Data related to screening for behavioral health concerns can be used to identify behavioral health staffing needs, as well as to target at-risk populations more effectively. Research on cost-effectiveness of these behavioral health interventions can be useful to the primary care team members as they plan and make budgetary decisions. For example, measuring the physician time saved by using a “warm handoff” to a psychologist when a behavioral health concern is raised during a well-child visit can demonstrate the value of psychologists as it relates to

outcomes directly relevant to physicians. As illustrated in Table 1, these data can also contribute to a growing body of literature on efficiency and effectiveness in the IPC setting.

Professionalism

As we strive to collaborate with multiple disciplines in integrated settings, the clear understanding of, and ability to articulate the rationale for, professional boundaries becomes increasingly relevant, particularly as professional and social roles and boundaries may differ across disciplines.

As a result, professionalism in the primary care setting relies heavily on psychologists' understanding of the values, boundaries, and needs of other team members as they relate to psychologists' own values, boundaries, and needs. The appreciation of professional identities of other team members is thought to help pediatric psychologists understand and effectively execute their role on the primary care team. For example, value of the interprofessional team approach in pediatric primary care can be demonstrated by participation in team "huddles" and treatment planning; prompt, flexible, and efficacious response to team member requests; and solicitation of input from interprofessional colleagues in recognition that patient- and population-based care is the shared responsibility of the team. Woven through these interactions, competency in the professionalism domain is demonstrated through the respectful communication about the patient and family in the service of promoting patient-centered treatment planning and patient satisfaction.

Interpersonal

Effective interpersonal skills in the primary care setting require clear and compassionate communication combined with relationship building. These skills are essential for all psychologists in clinical practice, but they are particularly true when the psychologist is

extending beyond the clinician-patient relationship to forming relationships as a part of a larger treatment team. Within any medical team, there is a culture and set of values that a psychologist must understand and navigate to become a valued member of that team.

Pediatric psychologists in IPC are well positioned to promote comprehensive care for children and families. Within the IPC framework, they may also bring in additional behavioral health services to broaden programs available through the medical home. Providing such care could involve problem-focused treatment, facilitating additional behavioral health services (e.g., telehealth), and creating and evaluating programs to foster patient and family well-being at a variety of developmental stages.

Application

Competencies within the Application cluster relate to the delivery of clinical services in the form of assessment, intervention, and consultation. Throughout these competencies, there are many references to the need to follow an evidence-based practice model that integrates research, clinical expertise, and patient preferences and characteristics (Spring, 2007). Within the IPC setting, a psychologist must have a broad understanding of behavioral health, evidence-based treatments, and development throughout childhood and adolescence, while also having a strong appreciation for the role of a primary care psychologist, as well as types of patients and interventions appropriate for the primary care setting. For example, treatment of a child with emerging symptoms of depression is appropriate for identification and short-term treatment in the primary care setting, whereas an adolescent with more extensive and impairing depressive symptomatology may require a higher level of care outside of the scope of most primary care environments, where more frequent and intensive interventions can be offered along with additional models of safety monitoring. While there is a growing and robust evidence base for

treatment across a range of child and adolescent behavioral health concerns (Chorpita, Deleidon, & Weisz, 2005; Pelham & Fabiano, 2008; Weisz, Jensen-Doss, & Hawley, 2006), intervention research in the pediatric primary care setting is in its early stages. Though promising results are emerging surrounding the effectiveness of briefer, adapted versions of traditional mental health treatment protocols in addressing behavior problems in the IPC setting (Berkovits, O'Brien, Carter & Eyberg, 2010; Lavigne, et al, 2008), it is still not known if and how short-term interventions are effective in reducing behavioral and mental health concerns in a population based approach. The issue of “dosing” is an important consideration for an IPC psychologist, as well as evaluating the efficacy of providing briefer treatments and services for a broader range of patients and families as compared to longer-term, empirically validated practices for a smaller subset of a primary care population. When indicated, IPC psychologists have an opportunity to responsibly and ethically adapt evidence-based interventions developed for traditional behavioral health settings to primary care settings with briefer duration of services, more limited scope, and an emerging empirical base.

Given the volume of patients seen in the primary care setting, the need for behavioral health screening and targeted intervention is evident. In other words, the IPC psychologist often does work “upstream” of a specialty behavioral health practice, including identification, engagement, prevention, and selected interventions. For example, pediatric psychologists in IPC may facilitate screening for depression at all well visits for teenagers using a validated and free measure. Depending on the screening score, pediatric psychologists may guide the medical staff to triage teenagers to the appropriate level of behavioral health care. Ideally, anyone referred for treatment for depression would also have the opportunity to participate in a warm handoff or consultation with the psychologist during the well visit to reduce behavioral health

stigma and improve patient engagement in treatment. Throughout this process, the psychologist addresses emerging as well as enduring symptoms of depression at the levels of broader population health and individual behavioral health. In addition, the psychologist has to practice in a flexible manner to allow time for individual therapy and same-day consultations, which may require interruptions during therapy appointments. These interruptions are more consistent with the traditional medical setting than with an outpatient behavioral health setting where interruptions are less common and may require the psychologist to educate patients and families about the nature of treatment in the primary care setting.

Education

With a growing need for psychologists in IPC, there is also a need to train well-qualified students for entry into the field. Insufficient training and exposure to the primary care setting continue to be barriers to appropriate staffing of behavioral health clinicians in the IPC setting (Hall et al., 2015). Exposure to IPC settings by way of education on presenting conditions commonly faced by IPC psychologists and clinical training in primary care environments can also facilitate interest among psychology students at various levels of training.

Common topics for teaching and supervision may include normal development, toilet training, feeding, and sleep, and may extend to such topics as ADHD, anxiety disorders, trauma exposure, postpartum mood disorders, suicide assessment, substance abuse, child abuse, and many other behavioral health questions and concerns common to the primary care setting. They also reflect the promotion of preventative care and early intervention in the primary care setting.

Systems

The final set of competencies outlines our role in interprofessional systems, professional leadership, and advocacy. The behavioral anchors in this section articulate ways in which

pediatric psychologists can demonstrate these skills in the pediatric integrated primary care setting.

As in other pediatric settings, pediatric psychologists in IPC must possess a clear understanding of their roles. This understanding includes valuing contributions from and communication with other providers. Within the primary care setting, there are many opportunities for collaboration with other professionals to identify system-wide opportunities for improved communication and delivery of behavioral health services. Furthermore, leading or joining teams in identifying and tracking behavioral health goals and their impact on physical wellness indicators at different developmental levels are tasks well suited for pediatric psychologists.

Finally, as pediatric psychologists work to ensure their role in the primary care setting, there is a need for advocacy to support such efforts at the local, state, and national levels. Although there is a need for integrating behavioral health into primary care, legislation is not sufficiently in place to support the growth of pediatric psychologists in the field (Miller, 2015). As such, advocacy efforts to support the growth of the field and to support adequate payment by third parties for a psychologist's work in the primary care setting is needed to ensure that integration is both feasible and financially viable.

Discussion

Proactively defining our own markers of competence that specifically relate to improvement in quality of behavioral health care in pediatric primary care setting will be critical to long-term role stability in this new workplace. Competencies correlate with performance, which can then be used to assess the effectiveness of the integrated care team in promoting patient satisfaction and improved population health (Kaslow, 2004). As a result, the goal of the

behavioral anchors outlined is to merge competencies previously defined for primary care psychology and pediatric psychology (McDaniel et al., 2014; Palermo et al., 2014, respectively) to highlight the unique role of the pediatric psychologist in an IPC setting.

Given that several provider disciplines—including social work, psychiatry, counseling, health coaches, and nursing—are advocating for a behavioral health role in primary care, it is imperative that psychologists not only define, but also advocate for how our unique skill set is a good fit for this position. The behavioral anchors illustrate specific examples of how psychologists can merge and apply their pediatric and clinical child psychology training to be successful members of the primary care team. In particular, the versatility of psychologists as clinicians, researchers, and educators can be particularly appealing when looking to build a high performing integrated primary care team.

Next Steps

The implementation of these behavioral anchors could help inform the creation of assessment tools to quantify the role and success of a psychologist in IPC. As we improve our ability to assess the performance of pediatric psychologists in IPC, we can also systematically work to become more efficient and effective, in support of the goals outlined by the Triple Aim initiative. These behavioral anchors can also be used to steer psychologists' expanding role in promoting improved behavioral health among the pediatric population served, which has broader national implications for health care cost-effectiveness and general population health and well-being.

In addition, these behavioral anchors could be used to inform training so that psychology trainees and early career pediatric psychologists not only have the skills necessary to be effective IPC team members, but also so they have exposure to this growing field. There have been an

increasing number of studies demonstrating the effectiveness of integrating behavioral health services into the primary care setting (Asarnow et al., 2015; Kolko et al., 2014). As this evidence accumulates, there will continue to be a growing need for well-trained providers interested in practicing in this setting. Although the need is growing, adequate staffing of behavioral health clinicians in the primary care setting continues to be lacking (Davis et al., 2015), resulting in a growing need for psychologists in the pediatric IPC setting.

Although there are many applications for these behavioral anchors, there are also several limitations to consider. First, it is important to acknowledge that several of the behavioral anchors are overlapping, not only with each other but also with anchors defined for hospital-based pediatric psychologists. All anchors were included in an effort to be comprehensive, while also allowing clinicians to search within a specific competency for examples rather than requiring the document to be used only in its entirety. In addition, it should be noted that any one psychologist likely could not excel in all areas defined in this document. Likewise, depending on the funding and productivity model for the psychologist, some of the anchors may not be feasible. For example, when a fee-for-service model is used, some of the research, teaching, prevention, and advocacy anchors may be less relevant for the pediatric psychologist in an IPC setting, and instead the anchors related to direct patient care and collaboration with the pediatrician are the focus. Thus, these anchors are meant to be suggestive for professional areas of strength and competence and not definitive markers of competence in all areas. Finally, we acknowledge that there are many ways that one can demonstrate competencies and we are able to provide only a sampling of relevant examples.

Conclusion

Pediatric psychologists are well suited for IPC practice (Stancin & Perrin, 2014). The diverse clinical, research, and training skills of a pediatric psychologist allows them to contribute to the health care team in multiple ways. For example, they can contribute to the development of evidence-based screening and intervention for broad behavioral health concerns, while also contributing to program evaluation, cost-effectiveness, and quality improvement initiatives across the primary care setting. Given the strong interest in developing the role of the behavioral health clinician in the pediatric primary care setting, it is especially important to define the unique contributions of pediatric psychologists to enhance interest and opportunities to train in this unique setting among psychology students at diverse levels of training. By providing these behavioral anchors, we hope that we can further advocate for our role in this exciting and growing field of pediatric IPC.

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Appendix A

Table 1: Competencies and Behavioral Anchors for IPC Pediatric Psychologists

Abbreviations:

PC = primary care

IPC = integrated primary care

RCT = randomized controlled trial

NIH = National Institutes of Health

PCORI = Patient-Centered Outcomes Research Institute

SAMHSA = Substance Abuse and Mental Health Services Administration

HRSA = Health Resources and Services Administration

APA = American Psychological Association

HIPAA = Health Insurance Portability and Accountability Act

AAP = American Academy of Pediatrics

EMR = Electronic Health Record

ADHD = Attention Deficit Hyperactivity Disorder

BH = Behavioral/Mental Health

IEP = Individualized Education Program

PCP = Primary Care Provider

PDSA = Plan-Do-Study-Act

Mini CEX = Mini Clinical Evaluation Exercise

2. SCIENCE CLUSTER

2.A. Research and evaluation methodology

SPP Competency (Palermo et al., 2014)	IPC –Specific Behavioral Anchors
2.1.A. Conducts pediatric research in multiple settings (e.g., medical, home, school), applying sound research methodology, data collection techniques, and data analytic approaches	<ul style="list-style-type: none"> • Implements well-designed, feasible studies that inform pediatric IPC systems and/or practice in collaboration with an interprofessional team in multiple settings. • Participates in pediatric IPC practice-based research networks when feasible. • Presents findings at conferences or in journals targeting a

	variety of disciplines (e.g. psychology, medicine, nursing).
2.2.A. Effectively uses research skills to evaluate practice, intervention, and program outcomes and processes in community-based and health-care settings	<ul style="list-style-type: none"> Identifies and prioritizes research areas of inquiry that will enhance pediatric IPC systems and/or practice (e.g., cost effectiveness data, quality of service delivery, factors impacting successful transition to adult care). Measures the impact of rendered services and community coordination on patient, family, provider, and systems-level outcomes in IPC settings. Targets outcome variables of specific interest to pediatric IPC practice (e.g. health-care utilization, developmentally appropriate screening practices). Uses brief patient and provider outcome measures in IPC clinic and community-based (e.g., school/non-clinic satellite/mobile clinic-based health services, etc.) settings when appropriate.
2.3.A. Acquires familiarity with clinical trial methodology and reporting, systematic reviews, and research strategies to enable conduct of research to inform evidence-based practice	<ul style="list-style-type: none"> Maintains up-to-date knowledge about research methodologies commonly used in pediatric IPC research teams (e.g., RCTs, quality improvement initiatives). Conducts systematic literature searches on areas of inquiry pertinent to pediatric IPC using databases from multiple disciplines (e.g. public health, medicine, nursing, psychology, social work).
2.4.A. Acquires familiarity with methods of intramural and extramural funding for pediatric psychology research	<ul style="list-style-type: none"> Demonstrates knowledge of major extramural funding agencies targeting IPC programs (e.g., NIH, PCORI, HRSA Bureau of Primary Health Care, SAMHSA) and their processes. Identifies internal funding mechanisms to support pediatric IPC initiatives (e.g., small grants for additional screening materials, etc.). Is familiar with the process of writing and submitting a grant application.

2.B. Ethical conduct of research in children

2.1.B. Understands and applies local and federal regulations for the protection of children involved as subjects in research	<ul style="list-style-type: none"> • Demonstrates understanding of the treatment of human subjects in pediatric IPC settings, particularly conducting ethical research with children, and how to develop protocols for institutional review boards.
2.2.B. Understands and appropriately handles ethical issues relating to interdisciplinary research in pediatric populations	<ul style="list-style-type: none"> • Effectively obtains informed consent and assent when conducting research in IPC. • Protects subject confidentiality in the work flow of a pediatric IPC setting among various professionals. • Follows, teaches and models relevant ethical principles when involved with trainees and colleagues on interprofessional research projects in pediatric IPC. • Navigates the ethical issues involved in authorship of pediatric IPC interdisciplinary publications.

2.C. Interdisciplinary research

2.1.C. Functions within interdisciplinary research teams to address diverse research questions in pediatric psychology	<ul style="list-style-type: none"> • Collaborates with other pediatric IPC team members (e.g. pediatricians, nurses, social workers) to address child health research questions of broad interest. • Advises interprofessional team members in strategies for effectively evaluating pediatric IPC costs, quality and/or outcomes. • Collaborates on interprofessional funding of proposals and pilot projects aimed at qualifying for larger grant funding for pediatric IPC initiatives.
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2.D. Dissemination and knowledge transfer

2.1.D. Develops and uses effective strategies to translate research findings to multiple audiences	<ul style="list-style-type: none"> • Presents and tailors research findings to various professional and patient/family groups, including non-traditional didactic
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such as other psychologists, medical professionals, patients, community providers, media, funding agencies, and policy and decision makers	<p>formats (e.g., co-service delivery teams, informal lunch presentations).</p> <ul style="list-style-type: none"> • Engages youth and family advisory boards to generate ideas for dissemination of research findings. • When appropriate, contributes to the preparation of information about study findings for other pediatric IPC professionals, study participants and families. • Creation of pertinent documents for the general public.
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3. Professionalism Cluster

3. A. Professional values and attitudes

Competency	Behavioral Anchor
3.1.A. Exhibits professionalism in interactions with patients, research participants, and their families	<ul style="list-style-type: none"> • Is respectful of the time demands of others (e.g., healthcare providers, patients and their families, research participants) and makes efforts to be on-time and efficient within the fast-paced and unpredictable pediatric IPC environment. • Demonstrates mutual respect for patients and their families by eliciting feedback/shared decision-making when developing treatment plans and goals. • Speaks respectfully about patients, and their families when sharing consultation information with other providers.
3.2.A. Provides clinical care to children and families, implementing appropriate personal boundaries	<ul style="list-style-type: none"> • Is aware of challenges unique to a psychologist working within an integrated medical team (e.g., boundaries different for medical providers versus psychologists), and sets appropriate boundaries when needed (e.g., IPC team members asking for behavioral health advice for themselves or their families). • Demonstrates respect for others (e.g., medical providers, patients, and their families) by offering rationale for maintaining personal boundaries in accordance with APA Ethics Code.
3.3.A. Works effectively with colleagues from other	<ul style="list-style-type: none"> • Learns from and with interprofessional members of the

disciplines (e.g., nursing, pediatrics, social work) to maintain a climate of mutual respect and shared values	<p>pediatric IPC team, clarifying each other's expertise, roles, and responsibilities to enable effective education, collaboration and team participation and leadership.</p> <ul style="list-style-type: none"> • Values an interprofessional team approach to pediatric IPC as demonstrated by one or more of the following areas: participation in team “huddles” and treatment planning; prompt, flexible, and efficacious response to team member requests; solicitation of input from interprofessional colleagues in recognition that patient and population based care is the responsibility of the team.
3.4.A. Utilizes ongoing educational opportunities that are provided (e.g., seminars, lectures, grand rounds, workshops) to gain greater knowledge regarding the professional practice of pediatric psychology and the areas of medicine relevant to pediatric psychology	<ul style="list-style-type: none"> • Participates in interprofessional continuing education opportunities focused on evidence-based skill development for effective practice in pediatric IPC. Sponsoring venues may include work sites, local hospitals, and state and national professional associations representing a range of health-care disciplines in addition to psychology (e.g., pediatrics, family medicine, nursing, social work, marriage and family therapy, public health). • Collaborates with colleagues from other health care disciplines to provide in-service trainings in the pediatric IPC setting as well as off-site educational programs, (e.g., presentation on trauma reactions in mothers and their children at a domestic violence shelter-based clinic for healthcare providers) thereby expanding one's own and others' expertise relevant to cost, quality and patient outcomes and practice in pediatric IPC.

3.B. Individual and cultural diversity

Competency	Behavioral Anchor
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<p>3.1.B. Works effectively with diverse patients and families, as well as diverse professionals (e.g., age, gender, race/ethnicity, socioeconomic background) in providing and coordinating care</p>	<ul style="list-style-type: none"> • Demonstrates awareness, understanding, and sensitivity to issues of cultural, racial, ethnic, religious, sexual and other diversity and individual differences in consultation, assessment and treatment with children and families, and their varying relationships with IPC team members. • Communicates information about differing levels of acculturation between caregiver and child to IPC team and families. • Assists in educating interprofessional team members as to how development and diversity issues may impact the patient's or family's understanding of the prevention or management of medical and/or behavioral health conditions. • Advocates for the patient and family in creating comprehensive, developmentally appropriate preventive care and treatment plans that incorporate the family's unique cultural beliefs. • Reflects upon and is mindful of potential ways one's own cultural, racial, and other identity impacts professional work.
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3. C. Ethical, legal standards, and policy

<p>3.1.C. Applies professional standards associated with practice in pediatric care settings</p>	<ul style="list-style-type: none"> • Discusses issues of confidentiality and informed consent and assent with patients, families and other providers, and demonstrates awareness and understanding of HIPAA principles, particularly pertaining to the complexities of protecting children's health information (e.g., obtaining consent from appropriate caregivers and releasing information only to guardian approved proxies). • Conducts periodic literature reviews to remain abreast of clinical findings and innovations related to pediatric IPC.
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	<ul style="list-style-type: none"> • Aware of and advocates for the implementation of relevant clinical practice guidelines related to behavioral health.
3.2.C. Applies the local behavioral health laws and APA guidelines regarding the rights of children and caregivers especially pertinent to pediatric psychology practice	<ul style="list-style-type: none"> • Remains familiar and well-versed regarding HIPAA, local behavioral health and child welfare laws, policies, and APA guidelines relevant in pediatric IPC settings (e.g., age of consent). • Assists in educating interprofessional team members about such matters.

3. D. Reflective practice/self-assessment/self-care

Competency	Behavioral Anchor
3.1.D. Engages in reflective practice conducted with personal and professional self-awareness, including attention to one's health behaviors and reactions to working with children and families under stress	<ul style="list-style-type: none"> • Appropriately seeks support, feedback, and input about professional strengths and areas for growth from interprofessional team members. • Creates a support and consultation network with other pediatric IPC psychologists and behavioral health providers. • Models and promotes self-care activities (e.g., bringing healthy lunch to work, engaging in physical activity on a regular basis, modeling adaptive coping on busy clinic days) for other pediatric IPC professionals.
3.2.D. Conducts self-assessments to continuously improve services offered	<ul style="list-style-type: none"> • Uses an array of feedback sources (e.g. patient and caregiver satisfaction, health professional satisfaction, needs assessments) to gain understanding of strengths and weaknesses of pediatric IPC program. • Is aware of general clinic operations and is personally responsive to evolving needs of the clinic staff and patient population (e.g. is considerate of consultation approach to reduce time burden on patients and staff, assists with implementing screening procedures in clinic).

4. Interpersonal**4. A. Communication**

Competency	Behavioral Anchor
4.1.A. Uses and facilitates accurate, clear, and effective communication with and between patients, their families, other health-care professionals, community institutions, and systems involving the patient	<ul style="list-style-type: none"> • Emphasizes use of respectful and appropriate communication in the pediatric IPC clinic setting and common collateral contacts (e.g., school) that is matched to the target audience. • Works to ensure that patients, families, and care team members have a clear understanding of presenting problems, priorities, recommendations, and integrated care team impressions. This includes using developmentally appropriate language and explanations for children and adolescents. • Provides written instructions (e.g., after visit summaries, patient instructions printed from EMR) to patients and families when appropriate using language fitting developmental and literacy levels of youth and caregivers.

4. B. Relational

Competency	Behavioral Anchor
4.1.B. Supports a team approach to the maintenance and promotion of health and treatment of disease	<ul style="list-style-type: none"> • Encourages effective communication between pediatric IPC team members regarding patient functioning, treatment plans, developmental factors impacting service delivery, and identification of patients who would benefit from direct behavioral health services. • Promotes consideration of more holistic perspectives by eliciting ideas about biopsychosocial and developmental factors contributing to health behaviors and disease expression.
4.2.B. Develops and maintains relationships with patients, their families, other professionals, communities, and other systems involving patients	<ul style="list-style-type: none"> • Works to build rapport and open communication between patients, families and care team members through respect, support, and evidence-based recommendations. • Demonstrates mutual respect for patients, their families, and IPC care team members by eliciting feedback/shared decision-

	<p>making when developing treatment plans/goals.</p> <ul style="list-style-type: none"> • Establishes and maintains referral networks of community partners based on input from families and external systems. • Works to collaborate with community and professional partners to bring in additional services to the pediatric IPC clinic (e.g., coordinating behavioral telehealth services for rural youth).
4.3.B. Effectively manages challenging relationships and interactions	<ul style="list-style-type: none"> • Proactively helps team members identify sources of impasse (e.g., issues related to adherence or trust in the medical team) with patients and families and compassionately discuss solutions to promote patient and family health and well-being. • Encourages team members to help patients and families actively engage in the healthcare process. • Makes an effort to thoughtfully engage in problem solving and address sources of avoidable tension or clashes between team members and with patients and families (e.g., balancing support for age-appropriate autonomy in adolescents when their wishes might differ from their caregivers').

5. APPLICATION CLUSTER

5.A. Practice Management

5.1.A. Meets the needs of patients, their families, other team members, and the setting, taking into consideration the model of behavioral health/PC integration used, resources available, and time constraints within the setting	<ul style="list-style-type: none"> • Uses needs assessment information administered to providers and families to develop and allocate clinical services (e.g., identify topics for parent lectures, symptoms or conditions targeted in group therapy), considering the unique community-based needs of the pediatric IPC practice. • Implements and schedules clinical services in a manner that effectively fits within pediatric IPC model of service delivery (e.g., higher volume and shorter appointments than in specialty behavioral health, available for warm handoffs during well-child, sick, and/or pre-natal visits).
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	<ul style="list-style-type: none"> • Distributes appropriate intervals between appointments when warranted, as opposed to treating patients on a weekly basis.
5.2.A. Applies principles of population based care along a continuum from prevention and wellness, to subclinical problems, to acute and chronic clinical needs	<ul style="list-style-type: none"> • Implements population based screening for child and adolescent behavioral health conditions (e.g., depression, accidental injuries). • Assists practice to provide assessment and intervention across continuum of health and illness regardless of whether or not there is a diagnosable behavioral health disorder (e.g., providing preventive services such as parent education, Mom and Baby groups, Reach Out and Read programs, etc.; explaining developmental expectations during well-child visits; providing parent training for caregivers of youth with emerging behavior concerns). • Applies interventions appropriate to the pediatric IPC setting (e.g., motivational interviewing, behavior therapy).
5.3.A. Operates at a variety of paces consistent with the needs and realities of PC	<ul style="list-style-type: none"> • Uses appointment time efficiently and allocates appointment time based on patient need. • Uses information available from patients' medical charts and other PC providers to inform data collected during appointments. • Makes time for "warm handoffs" from physicians and staff triaging patients with greater needs.
5.4.A. Can co-interview, co-assess, and co-intervene with other PC providers	<ul style="list-style-type: none"> • Works with pediatrician and other pediatric IPC providers to conduct interviews with children and caregivers and develop treatment plans. • Co-facilitates assessments and progress monitoring with other health care providers by assisting in gathering relevant behavioral, developmental, and social history.
5.5.A. Understands how payment for services may influence the type of services and treatment provided	<ul style="list-style-type: none"> • Informs family when recommended tests or treatments (e.g., for learning disabilities or certain behavioral health diagnoses) may not be covered by insurance, and assists in identifying alternative resources where they may be paid (e.g., school systems for learning disability assessment; linking families to

	<p>advocacy resources in the community).</p> <ul style="list-style-type: none"> • Understands local regulations concerning coverage for services such as academic testing and same-day billing restrictions for multiple providers in the same practice.
5.6.A. Communicates information that addresses a patient's needs, improves PC practice and allows for IRB approved research	<ul style="list-style-type: none"> • Writes clear, concise notes focused on referral problem, functional impairment, and specific recommendations provided to family. • Ensures notes are accessible and comprehensible to pediatric IPC team and is aware and mindful of who outside the pediatric IPC system has access to notes. • Completes all intakes and notes in a timely manner. Uses templates and dictation within the EMR when appropriate.
5.7.A. Uses up to date technology and methods to guide clinical service delivery	<ul style="list-style-type: none"> • Directs families to age-appropriate web-based resources and applications to provide education and assist with symptom management. • Uses accessible technology in session to assist in teaching techniques (e.g., video demonstrations, YouTube clips of Deep Breathing) and monitoring correct implementation of strategies. • Uses handouts and videos for patients and caregivers that are evidence-based and applicable to pediatric IPC settings.

5.B Assessment

5.1.B. Flexibly uses multiple methods of assessment to address presenting concerns in ways that are responsive and respectful of the diverse needs of children, caretakers, family, and referral sources	<ul style="list-style-type: none"> • Seeks out necessary and relevant information in real time from patient's medical provider, medical record, patient, and caregivers as related to the presenting concerns. • Relies on knowledge of the particular community and various cultures represented by the patients of the pediatric IPC practice to guide assessment. • Guides practice to use developmentally appropriate screening measures that have been adequately validated in other languages in addition to English.
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<p>5.2.B. Effectively assesses biopsychosocial, developmental, environment, and family system factors that can impact children's coping and adaptation to health</p>	<ul style="list-style-type: none"> • Using biopsychosocial and developmental models, independently conducts brief, targeted assessments and integrates presenting concerns by gathering data from multiple relevant and available data sources within timelines appropriate for a pediatric IPC practice.
<p>5.3.B. Selects, administers, scores, and interprets biopsychosocial and cognitive assessment tools appropriate to the child's developmental level and health concern for various purposes</p>	<ul style="list-style-type: none"> • Selects, administers, scores, and interprets brief evidence-based assessment tools appropriate for a pediatric IPC setting. Typically this involves use of widely available, free measures that are familiar to pediatricians and other child health-care providers, supplemented by other psychometrically valid psychological assessment instruments as needed. • Implements developmentally appropriate screening for behavioral health and behavioral conditions (e.g., depression, anxiety) and applies interventions appropriate to the pediatric IPC setting (e.g., motivational interviewing, brief behavioral interventions). • Uses assessment information for treatment planning, monitoring and evaluating treatment quality and outcomes, and facilitating community based referrals across commonly occurring as well as atypical case presentations.
<p>5.4.B. Effectively communicates the results of assessments in written and verbal form appropriately tailored for various consumers (e.g., patients, other medical professionals) and professional contexts (e.g., team meeting, disability evaluation, family meeting)</p>	<ul style="list-style-type: none"> • Briefly and succinctly documents assessment results in the medical record and communicates results of assessments to relevant health care providers, caregivers, and patients. Communications might occur during or between patient visits, as well as in the medical record, and may be written, verbal, or both, depending on the needs of the patient and team. • The level of detail for written and verbal summaries is tailored to the audience such that sensitive information is left out or stated in general terms to preserve the appropriate level of patient confidentiality (e.g., details about a child's trauma history is not included in a written report for medical providers).

5.C. Intervention	
5.1.C. Demonstrates treatment planning skills, including case conceptualization, appropriate to the health concern and developmental status of the patient and family	<ul style="list-style-type: none"> • Develops treatment plans based on evidence-based assessments that are time-limited, and appropriate to the pediatric IPC practice setting as well as patient and family characteristics and culture. • Effectively differentiates between treatment plans that can be implemented within the pediatric IPC setting and those that require referral to specialty behavioral health care.
5.2.C. Implements evidence-based biopsychosocial treatment interventions to support overall treatment goals	<ul style="list-style-type: none"> • Implements evidence-based biopsychosocial interventions appropriate to a pediatric IPC setting (e.g., short-term, problem-focused, targeting concerns of mild-moderate severity). • Liaises with other pediatric IPC providers in the implementation of biopsychosocial interventions tailored to patients' developmental levels. • Is proficient in evidence-based practices assessing and treating the most common behavioral conditions presenting in pediatric IPC practice (oppositional behavior, ADHD, academic problems, sleep disorders, enuresis, anxiety, developmental delays, etc.). • Routinely assesses for and incorporates into treatment plan, as needed, patient and family factors that might impact treatment recommendations and fidelity (e.g., developmental level, economics, school issues, work schedules, parent BH issues, transportation).
5.3.C. Implements evidenced-based wellness, health promotion, and prevention interventions appropriate to the health concern	<ul style="list-style-type: none"> • Works across the pediatric IPC team to develop and implement health promotion and prevention initiatives, (e.g., universal depression screening, participation in well child visits, supporting wellness and exercise recommendations).
5.4.C. Effectively communicates about progress/treatment updates in written and verbal form appropriately tailored for various consumers (e.g., patients, other medical professionals) and	<ul style="list-style-type: none"> • Provides effective written communication within the medical record and verbal communication during hallway consults, provider meetings, family/patient meetings, and community based contexts (e.g., representing pediatric team perspective at

professional contexts (e.g., team meeting, family meeting)	child's IEP meeting at school).
5.5.C. Integrates best available research with clinical expertise in the context of patient illness, characteristics, culture, and preferences	<ul style="list-style-type: none"> • Demonstrates awareness of the cultural context of the pediatric IPC practice and independently tailors best available, empirically supported interventions to practice within this cultural context and in keeping with patients' development.

5.D. Consultation

5.1.D. Provides consultative/liaison services to health-care professionals across disciplines and systems related to health and behavior	<ul style="list-style-type: none"> • Provides guidance regarding behavioral, developmental, and psychosocial conceptualizations and recommendations to other health care professionals using non-technical language that can be readily understood and that leads to implementation in the pediatric IPC setting. • Provides advice based upon empirical, evidence-based findings when providing information or a clinical opinion to health care personnel. • Effectively summarizes and communicates information to pediatric IPC providers regarding patient needs.
5.2.D. Translates and communicates relevant clinical findings as they bear on health-care consultation/liaison questions	<ul style="list-style-type: none"> • Provides and interprets assessment and treatment findings relevant to the reason for referral and provides guidance for potential required changes in treatment. • As needed, assists in designing data collection procedures to answer consultation questions that are applicable to pediatric IPC settings and time limitations (e.g., assessment regarding adherence to asthma treatment protocols).

6. EDUCATION CLUSTER

6.A. Teaching

<p>6.1.A. Applies teaching strategies that demonstrate understanding of the knowledge, skills, and competencies required to be a primary care pediatric psychologist</p>	<ul style="list-style-type: none"> • Develops curriculum and training materials addressing most common psychological, social, and developmental issues encountered in pediatric IPC (i.e., developmental concerns, behavior problems, ADHD, school avoidance, enuresis & encopresis, and sleep). • Evaluates effectiveness of teaching methods and procedures with interprofessional staff and trainees in pediatric IPC, coordinating training of interprofessional learners with system wide educational initiatives. • Creates opportunities for trainees to learn from interprofessional colleagues and facilitates teaching of psychology trainees by other health care professionals located in the pediatric IPC facility.
<p>6.2.A. Provides education and training to psychologists, other health care professionals, and trainees on pediatric psychology approaches to biological, cognitive, affective, sociocultural, and life span developmental influences on children's health and illness</p>	<ul style="list-style-type: none"> • Educates and trains psychologists and psychology trainees regarding physical and behavioral health promotion, disease prevention developmental understanding of illness, and management of acute and chronic illnesses in childhood and adolescence. • Demonstrates familiarity with and adapts to training models of other disciplines in pediatric IPC (e.g., Mini-CEX and Four Habits communication rubrics used in medical school and pediatric residency training programs). • Consults with physicians and staff in patient- and family-centered care when necessary or requested. • Modifies teaching strategies based on learner's needs (e.g., discipline-specific training, level of familiarity with pediatric behavioral health concerns, skill level of provider, etc.).
<p>6.3.A. Models and encourages commitment to the profession through professional conduct and integration of ethical principles</p>	<ul style="list-style-type: none"> • Provides informed consent and assent information to patients and caregivers regarding collaboration with other providers in pediatric IPC and implications for confidentiality. • Models respectful communication regarding developmental and caregiver mental/behavioral health conditions, family stressors, and other individual difference and system factors

	<p>impacting child health.</p> <ul style="list-style-type: none"> Creates mentor networks of pediatric IPC health professionals across institutions.
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6.B. Supervision

6.1.B. Outlines competency expectations for pediatric psychologists and regularly provides feedback to trainees on progress.	<ul style="list-style-type: none"> Consolidates data from interprofessional supervisors/mentors and synthesizes feedback into meaningful guidance.
6.2.B. Provides effective supervision to pediatric psychology trainees, as well as trainees and staff from other health professions pertaining to pediatric psychology principles.	<ul style="list-style-type: none"> Customizes supervision strategies based on learner's needs unique to pediatric IPC clinics (e.g., curbside supervision and shadowing). Assesses knowledge and provides teaching to develop supervisee's competence in content areas relevant to pediatric IPC psychology (e.g. normal development, toilet training, feeding, sleep). Monitors supervisees in meeting time objectives for sessions, keeping appointments moving throughout the day, efficient documentation, and ensuring appropriate feedback regarding cases is shared with referring providers.

7. SYSTEMS CLUSTER

7.A. Interdisciplinary Systems

7.1.A. Understands basic principles of systems theory as applied to pediatric psychology practice settings, including inpatient hospital, outpatient clinics and private practice, schools, and the larger community	<ul style="list-style-type: none"> Understands the role of pediatric IPC services within the context of the larger healthcare delivery system. Applies systems theory to understand the culture of practice within specific pediatric IPC settings.
7.2.A. Understands both the unique and overlapping roles, responsibilities, and interrelationships of	<ul style="list-style-type: none"> Values and seeks out input from other providers on the pediatric IPC team.

multiple disciplines within each of these service delivery systems	<ul style="list-style-type: none"> • Respects the role of the primary care provider as the head coordinator of services, while also being able to lead the team related to the specific behavioral health needs of individual patients. • Develops relationships to function as a valued team member.
7.3.A. Understands the basic knowledge, perspectives, service delivery systems, and contributions of other health-care disciplines	<ul style="list-style-type: none"> • Identifies opportunities to collaborate across disciplines. • Demonstrates understanding of the training, roles, and responsibilities across pediatric IPC team providers. • Knows with whom to communicate and desired frequency of communication to promote quality collaborative care.
7.4.A. Understands how systems collaboration enhances outcomes and how to evaluate effective outcomes in each of these contexts	<ul style="list-style-type: none"> • Leads or joins teams in identifying and tracking behavioral health goals and their impact on physical wellness indicators. • Collaborates with other professionals to identify system-wide opportunities for improved communication and delivery of pediatric IPC behavioral health services.
7.5.A. Has knowledge of systems-based assessment approaches and interdisciplinary interventions across different treatment settings, including outpatient and inpatient settings, schools, and the community	<ul style="list-style-type: none"> • Contributes to the knowledge and implementation of developmentally appropriate behavioral health screening in pediatric IPC settings. • Helps develop and implement systematic pathways to pediatric IPC-based evidence-based behavioral health interventions. • Develops knowledge of and pediatric IPC referral procedures for various community agencies in the child BH service delivery system.
7.6.A. Has knowledge of and can apply continuous performance improvement (CPI) models	<ul style="list-style-type: none"> • Leads and/or participates in efforts to engage staff in CPI initiatives related to behavioral health. • Effectively monitors improvements in quality and efficiency in integrated care settings.

7.B. Professional leadership development

7.1.B. Engages in the role of the pediatric psychologist as a knowledgeable team member who	<ul style="list-style-type: none"> • Works effectively and independently within an interprofessional team in pediatric IPC settings.
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shares understanding of the behavioral aspects of medical disorders, including etiology, assessment, and treatment	<ul style="list-style-type: none"> • Contributes to considerations of behavioral health by other professionals in pediatric IPC settings.
7.2.B. Is familiar with roles of management, administrators, and other peer team members in the medical setting, school setting, and community as they relate to pediatric psychology practice	<ul style="list-style-type: none"> • Provides appropriate leadership for coordinating delivery of child behavioral health services in pediatric IPC settings (e.g., initiates CPI processes to address concerns when a need is voiced by multiple health care providers on the team). • Provides appropriate leadership regarding the integration of behavioral health in the workflow of pediatric IPC settings (e.g., designs and oversees PDSA cycles examining new behavioral health screening algorithms).

7.C. Advocacy (local, state, national)

7.1.C. Advocates for pediatric psychology as an evidence-based science and profession in outpatient and inpatient settings, schools, and communities at the local, state, and national level	<ul style="list-style-type: none"> • Advocates for pediatric psychology services in pediatric IPC settings. • Provides ongoing education (e.g., by example, in conversation, and through scholarly and community presentations) to other health-care professionals in the skills, scholarship and perspective of pediatric psychologists.
7.2.C. Advocates for access to behavioral health care at all levels of the health-care system (i.e., individual, family, institutional, and political)	<ul style="list-style-type: none"> • Demonstrates recognition of the role of professional and state psychology associations in advocacy for policies that ensure inclusion of psychology in pediatric IPC settings. • Demonstrates basic understanding of the mechanisms and models for financing pediatric psychology services in pediatric IPC and their effect on access to care.